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Supreme Court, U.S.
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No. 04-623

IN THE
SUPREME COURT OF THE UNITED STATES

John Ashcroft, Attorney General, *et al.*,

Petitioners,

v.

State of Oregon *et al.*,

Respondents.

On Petition for Writ of Certiorari to the
United States Court of Appeals
for the Ninth Circuit

RESPONDENTS' BRIEF IN OPPOSITION
filed by Peter A. Rasmussen, M.D.
and David M. Hochhalter, RPh

ELI D. STUTSMAN
Counsel of Record
621 SW Morrison
Thirteenth Floor
Portland, OR 97205
(503) 274-4048

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QUESTION PRESENTED

Exercising its traditional police powers, Oregon enacted laws and regulations that allow physicians to prescribe and pharmacists to dispense Schedule II controlled substances to competent, terminally-ill adults who may use them under strictly regulated conditions to choose the time, place, and manner of their impending deaths. In enacting and amending the Controlled Substances Act (CSA), did Congress clearly authorize the Attorney General to determine that physicians and pharmacists acting in accordance with those Oregon laws have violated the CSA?

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INTRODUCTION

One day after the State of Oregon filed suit, respondents Peter A. Rasmussen, M.D., and David M. Hochhalter, Rph, both of whom are registered with the Drug Enforcement Administration (DEA), filed a complaint in intervention suing United States Attorney General John Ashcroft, *et al.*, to prevent criminal and civil enforcement proceedings against them for having prescribed and dispensed controlled substances under the Oregon Death With Dignity Act, Or. Rev. Stat. 127.800 *et seq.*

STATEMENT OF THE CASE

A. *Proceedings below*

On November 8, 2001, the district court granted respondents' request for a temporary restraining order, enjoining the Attorney General from enforcing the CSA against Oregon physicians and pharmacists practicing in accord with the Oregon Death With Dignity Act. CR 20.

On November 20, 2001, at the conclusion of the preliminary injunction hearing, the parties agreed to extend the TRO in lieu of a court ruling on plaintiffs' motion for a preliminary injunction. CR 60.

On April 17, 2002, the district court granted summary judgment in favor of all plaintiffs, enjoining the Attorney General from enforcing, applying, or otherwise giving any legal effect to his enforcement directive. *See*, Pet. Cert., 97a. The district court reasoned as follows:

> I conclude that Congress did not intend the CSA to override a state's decisions concerning what constitutes legitimate medical practice, at least in the absence of an express federal law prohibiting that practice. Similarly, I conclude that Congress never intended, through the CSA or through any other current federal law, to grant blanket authority to the Attorney General or the DEA to define, as a matter of federal policy, what constitutes the legitimate practice of medicine.

Pet. Cert., 97a.

On May 26, 2004, the Ninth Circuit affirmed the district court's analysis, finding that the enforcement directive is unlawful and unenforceable because it:

> [1] violates the plain language of the CSA, [2] contravenes Congress' express legislative intent, and [3] oversteps the bounds of the Attorney General's statutory authority.

Pet. Cert., 2a; *see, also, id.* at 9a:

> We hold that the Attorney General lacked Congress' requisite authorization. The Ashcroft Directive violates the "clear statement" rule, contradicts the plain language of the CSA, and contravenes the express intent of Congress.

The Ninth Circuit concluded its analysis as follows:

> In sum, the CSA was enacted to combat drug abuse. To the extent that it authorizes the federal government to make decisions regarding the practice of medicine, those decisions are delegated to the Secretary of Health and Human Services, not to the Attorney General. The Attorney General's unilateral attempt to regulate general medical practices historically entrusted to state lawmakers interferes with the democratic debate about physician assisted suicide and far exceeds the scope of his authority under federal law. We therefore hold that the Ashcroft Directive is invalid and may not be enforced.

Id. at 24a.

The Attorney General now petitions this Court for review.

B. *The Attorney General's enforcement directive*

In a two page enforcement directive (Pet. Cert. 100a-1005a) released November 6, 2001, the Attorney General found as follows:

> 1. *Determination on Use of Federally Controlled Substances to Assist Suicide.* For the reasons set forth in the OLC Opinion, *I hereby determine that assisting suicide is not a "legitimate medical purpose"* within the meaning of 21 CFR § 1306.04 (2001), and that prescribing, dispensing, or administering federally controlled substances to assist suicide violates the CSA. Such conduct by a physician registered to dispense controlled substances may "render his registration * * * inconsistent with the public interest" and therefore subject to possible suspension or revocation under 21 U.S.C. 824(a)(4). This conclusion applies regardless of whether state law authorizes or permits such conduct by practitioners or others and regardless of the condition of the person whose suicide is assisted.

See, Pet. Cert., 1002a (emphasis added).

The Attorney General directed that his findings be immediately enforced:

> I hereby direct the DEA, *effective upon publication of this memorandum in the Federal Register*, to enforce and apply this determination, notwithstanding anything to the contrary in the June 5, 1998, Attorney General [Janet Reno]'s letter.

See, Pet. Cert., 102a-103a (emphasis added). The enforcement directive went into effect three days later upon being published in the Federal Register on November 9, 2001. *Id.* at 100a.

The Attorney General further dictated the enforcement strategy. The Oregon Death With Dignity Act[1] imposes statutory record keeping requirements upon physicians[2] and public reporting requirements upon the Oregon Department of Human Services.[3] The Attorney General concluded that those publicly held records would facilitate enforcement proceedings:

> 4. Enforcement in Oregon. * * * . Those records should contain the information necessary to determine whether those holding DEA registrations who assist suicides *in accordance with Oregon law* are prescribing federally controlled substances for that purpose in violation of the CSA * * * .

See, Pet. Cert., 103a-104a (emphasis added).

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[1] In his petition, the Attorney General appends only portions of the Oregon statute. The full text of the statute is appended here at App. 1-20.

[2] *See*, App. 9-10, Or. Rev. Stat. 127.855(1)-(7) (medical record documentation requirements).

[3] *See*, App. 11, Or. Rev. Stat. 127.865(3) (reporting requirements).

The Attorney General determined that the DEA had the authority to obtain those records, *id.* at 104a, and concluded his enforcement directive with a distribution instruction:

> 5. Distribution. Please ensure that this Memorandum and the OLC opinion on which it is based are promptly distributed to appropriate DEA personnel, *especially those with authority over the CSA in Oregon.*

Id. (emphasis added).

C. *The Oregon Death With Dignity Act*

In *Washington v. Glucksberg*, 521 U.S. 702 (1997), this Court declined to recognize a "generalized" constitutional right to a physician-assisted death.[4] Central to that result was the court's observation that, "the States are currently engaged in serious, thoughtful examinations of physician-assisted suicide and other similar issues." *Id.* at 719. "Our holding permits this debate to continue, as it should in a democratic society." *Id.* at 735. The issue is one that "is entrusted to the 'laboratory' of the States." *Id.* at 737 (O'Connor, J., concurring, joined by Justices Ginsberg and Breyer); *see, also, id.* at 738 (Stevens, J., concurring) and at 788 (Souter, J., concurring).

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[4] Respondents use the term "assisted death" in recognition of the fact that "assisted suicide" is still a crime in Oregon. *See,* App. 21, Or. Rev. Stat. 163.125(1)(b). It is preferable not to use the language of a crime when referring to non-criminal activity under Oregon law.

Oregon has been at the forefront of this debate. The Oregon Death With Dignity Act was adopted by the people of Oregon at the November 8, 1994 election. Three years later, on November 7, 1997, the people of Oregon decisively rejected, by a margin of 60 percent to 40 percent, a proposal to repeal the Oregon Death With Dignity Act. Two years after that, on June 30, 1999, Governor John Kitzhaber, M.D., signed into law Senate Bill 491, amending the Oregon Death With Dignity Act. *See, e.g.*, CR 103, 106. In sum, the Oregon Death With Dignity Act is a duly enacted state law, twice approved by Oregon voters, subsequently amended by the state legislature and signed into law by Oregon's governor, himself a medical doctor. It is a rare law that has been so thoroughly tested and approved by a state's democratic process.

REASONS TO DENY THE WRIT

1. *The Attorney General exceeds the role of his office and the scope of the CSA*

As both the district court and the Ninth Circuit held, quoted *supra*, the Attorney General, in issuing his enforcement directive, exceeds the role of his office and the bounds of the CSA as he enters this policy dispute with the State of Oregon. The district and circuit courts have squarely addressed this problem and respondents urge this Court to end this litigation now.

2. *The Attorney General misconstrues this Court's precedent*

The Attorney General's November 6, 2001 enforcement directive is premised upon a misapplication of this Court's May

14, 2001 decision in *United States v. Oakland Cannabis Buyer's Cooperative*, as follows:

> As you are aware, the Supreme Court reaffirmed last term that the application of federal law regulating controlled substances is uniform throughout the United States and may not be nullified by the legislative decisions of individual States. *See United States v. Oakland Cannabis Buyers' Coop.*, 532 U.S. 483 (2001).

Pet. Cert., 101a. Unlike the "medical marijuana" litigation emerging from California, however, the Oregon law (1) does not authorize or require the use of Schedule I banned drugs, (2) no one is asserting a "medical necessity" defense, and (3) Oregon has not sought to legalize what the CSA has banned. In sharp contrast to the California cases, the Oregon law requires only drugs that are lawfully prescribed in all 50 states,[5] and Oregon does not challenge the CSA's classification scheme. The Attorney General does not claim otherwise, and his steadfast reliance upon *Oakland Cannabis Buyers' Coop.*[6] is therefore misplaced.

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[5] The Attorney General concedes this point too. *See*, Pet. Cert., 17, fn 4; *see, also*, Affidavit of Peter A. Rasmussen, M.D., App. 22 ¶ 4 and App. 26 ¶ 17; Affidavit of David M. Hochhalter, RPh, App. 29 ¶ 5 and App. 31 ¶ 4.

[6] *See, e.g.*, Pet. Cert., 6, 10, 15, 16, 17, 20, 22, 26.

3. *The Attorney General fails to allow the integration of state and federal law*

There is no positive conflict between state and federal law such that the two "cannot consistently stand together." 21 U.S.C. 903 (Application of State law).[7] The Attorney General may enforce the "uniform national policy" intended by Congress to prevent illicit drug use, drug trafficking, and drug diversion and, contemporaneously, Oregon practitioners, registered with the Board of Medical Examiners and the DEA, may possess, prescribe, and/or dispense controlled substances within "the course of their professional practice." These two policies are not mutually exclusive.

The CSA describes unlawful conduct as follows:

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[7] Section 903 (Application of State law) provides:

> No provision of this title shall be construed as indicating an intent on the part of the Congress *to occupy the field in which that provision operates*, including criminal penalties, to the exclusion of any State law on the same subject matter *which would otherwise be within the authority of the State*, unless there is a positive conflict between that provision of this title and that State law so that the two cannot consistently stand together.

21 U.S.C. 903 (emphasis added).

(a) Unlawful acts

Except as authorized by this subchapter, *it shall be unlawful for any person knowingly or intentionally--*

(1) to manufacture, distribute, or dispense, or possess with intent to manufacture, distribute, or dispense, a controlled substance; * * * .

21 U.S.C. 841(a)(1) (emphasis added). Thus, it is a crime to (1) knowingly or intentionally (2) distribute or dispense a controlled substance, unless "authorized" by the Act. *Id.* Authorization is obtained by "registering" with the Attorney General:

> (2) Every person who dispenses, or who proposes to dispense, any controlled substance, *shall obtain from the Attorney General a registration* issued in accordance with the rules and regulations promulgated by him. * * * .

21 U.S.C. 822(a)(2) (emphasis added). Persons registered with the Attorney General are authorized to possess, manufacture, distribute, or dispense controlled substances to the extent authorized by their registration:

> **(b) Authorized activities.**
>
> Persons registered by the Attorney General under this title to manufacture, distribute, or dispense controlled substances * * * are authorized to possess, manufacture, distribute, or dispense such substances or chemicals * * * *to the extent*

> *authorized by their registration and in conformity with the other provisions of this title.*

21 U.S.C. 822(b) (emphasis added). A physician registered with the Attorney General is a "practitioner" authorized to dispense controlled substances, *see*, 21 U.S.C. § 829(a)&(b), in "the course of professional practice," as follows:

> (21) The term "practitioner" means a *physician*, dentist, veterinarian, scientific investigator, pharmacy, hospital, or other person licensed, *registered, or otherwise permitted, by the United States or the jurisdiction in which he practices* or does research, to distribute, dispense, conduct research with respect to, administer, or use in teaching or chemical analysis, a controlled substance *in the course of professional practice* or research.

21 U.S.C. 802(21), formerly 802(20), (emphasis added).

This Court, in *United States v. Moore*, 423 U.S. 122 (1975), clarified that the course of professional practice standard is the applicable standard under the CSA:

> * * * the CSA uses the concept of "registration." Section 822(b) defines the scope of authorization under the Act in circular terms: "Persons registered under

> this subchapter are authorized to dispense controlled substances to the extent authorized by their registration and in conformity with the other provisions of this subchapter." *But the scheme of the statute, viewed against the background of the legislative history, reveals an intent to limit a registered physician's dispensing authority to the course of his "professional practice."*

Moore, 423 U.S. 122, 140 (emphasis added, internal ellipses, brackets and footnotes omitted). Under this statutory scheme, the Attorney General may enforce the uniform national policy intended by Congress to prevent illicit drug use, drug trafficking, and drug diversion, and Oregon practitioners may possess, prescribe, and dispense controlled substances in the "course of their professional practice." The Attorney General simply erred when he applied his own subjective standard:

> Nothing in either the CSA or its implementing legislation makes the definition of *legitimate medical purpose* dependent upon state law.

Pet. Cert., 19 (emphasis added).

4. *The Attorney General misuses the regulatory phrase "legitimate medical purpose"*

The regulatory phrase "legitimate medical purpose," upon which the Attorney General so heavily relies,[8] is not the value laden term the Attorney General portrays it to be. This phrase is not found in the CSA but is instead rooted in an agency rule and is therefore limited by the statutory phrase from which it is derived, "the course of professional practice," and it means the same thing. The Attorney General attempts to change the plain meaning of this statutory language by infusing into it new meaning derived from an agency rule:

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[8] *See, e.g.*, Pet. Cert., 9 ("the dissent observed that the Attorney General's conclusion that physician-assisted suicide is not a legitimate medical purpose is well supported by an 'overwhelming historical, legal, and medical consensus'"), 12 ("The Attorney General clearly acted reasonably in concluding that dispensing drugs to assist a person to commit suicide is not for a 'legitimate medical purpose' within the meaning of the CSA and his implementing regulation"), 12 ("numerous health care experts have agreed that physician-assisted suicide is not a legitimate medical treatment"), 13-14 ("The federal regulatory scheme is built upon the dual principles that the dispensing of controlled substances should be allowed for such 'legitimate medical purposes" but that distribution for illegitimate purposes should be prohibited"), 14 ("legitimate 'medical use' in 'treatment' therefore is a prerequisite to such dispensing"), 24 ("the determination whether dispensing drugs to facilitate suicide constitutes a 'legitimate medical purpose' turns on an interpretation of the CSA and a regulation of the Attorney General, and does not require an assessment of medical or scientific evidence").

> As this Court indicated in *Moore*, this *legitimate medical purpose* requirement is implicit in various provisions of the CSA, such as 21 U.S.C. 829, but is made explicit by virtue of the implementing regulation, 21 C.F.R. 1306.04(a). See, *Moore* 423 U.S. at 137-139 & n.13.

Pet. Cert. 4 (emphasis added). Correctly stated, this Court said:

> The only limitation on the distribution or dispensing of Schedule V drugs is that it be "for a *medical purpose*." s 829(c). The *medical purpose requirement* explicit in subsection (c) could be implicit in subsections (a) and (b). Regulation s 306.04 makes it explicit.

Moore, 423 U.S. at 137 n.13 (emphasis added). The Attorney General has thus transformed "medical purpose," a phrase consistent with the statutory "course of professional practice" standard, into the value laden term that he prefers, "legitimate medical purpose." This Court in *Moore* never went so far and a simple word search indicates that the phrase "legitimate medical purpose" was used only one time, in footnote 12, when the Court quoted the text of 21 CFR § 1306.04(a). 423 U.S. at 136-137 n.12. Elsewhere in his petition, the Attorney General concedes, as he must, that departure from the "course of professional practice" is the true standard from *Moore*:

> This Court held that the CSA was intended to limit a physician's distribution

> of controlled substances to actions "as a physician" and in the course of "professional practice." 423 U.S. at 140, 141.

Pet. Cert. 18. Nonetheless, the Attorney General repeatedly uses the language from the rule to the exclusion of the language from the statute as a rhetorical device to shift the debate to one about the legitimacy of medicine. For example, the Attorney General writes that he has "canvassed" the views of the medical community, state and federal law, and judicial opinions, and:

> despite Oregon voters' approval, physicians assisted suicide is not a "*legitimate medical purpose*."

Pet. Cert., 6 (emphasis added). Correctly stated, however, the question is whether the controlled substances at issue in Oregon are being prescribed or dispensed "in the course of professional practice," not whether a state's determination to allow a hastened death for a terminally ill, competent, adult patient is "legitimate" in the opinion of the Attorney General.

5. *The regulation of medicine belongs to the States*

The states, not the federal government, regulate medicine. *See, e.g., Linder v. United States*, 268 U.S. 5, 18 (1924) ("Obviously, direct control of medical practice in the states is beyond the power of the federal government."); *Barsky v. Board of Regents*, 347 U.S. 442, 449 (1953)("It is elemental that a state has broad power to establish and enforce standards of conduct within its borders relative to the health of everyone there. It is a

vital part of a state's police power."); *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 387 (2002) (determination of medical necessity and standards of reasonable care are "quintessentially state-law" determinations). Although the Attorney General criticizes *Linder*, *supra*, as an outdated *Lochner*-era opinion (Pet. Cert., 22, 27), similar propositions are found in *Barsky* and *Rush Prudential HMO*, *supra*.

The framers of the Constitution "split the atom of sovereignty" two ways: horizontally (among the three branches of government) and vertically (between the federal and state governments). *See, Alden v. Maine*, 527 U.S. 706, 714-15, 751 (1999); *Printz v. United States*, 521 U.S. 898, 921-22 (1997). As this Court recently explained:

> This separation of the two spheres is one of the Constitution's structural protections of liberty. "Just as the separation and independence of the coordinate branches of the Federal Government serve to prevent the accumulation of excessive power in any one branch, *a healthy balance of power between the States and the Federal Government will reduce the risk of tyranny and abuse from either front.*"

Printz, 521 U.S. at 921 (emphasis added); *quoting, Gregory v. Ashcroft*, 501 U.S. 452, 458 (1991).

The Congress, when legislating and later amending the CSA, was certainly aware of the traditional and constitutional

allocation of power that resides at the core of our federal form of government, and it expressly provided that, "absent a positive conflict," the CSA does not prohibit the states from legislating on, "subject matter which would otherwise be within the authority of the State." 21 U.S.C. 903 (Application of State law). Although the Attorney General concedes in his enforcement directive (Pet. Cert., 100a-105a) and supporting memorandum (*id.* at 106a-148a) that Oregon physicians and pharmacists are practicing medicine in accordance with Oregon law,[9] he offers only tortured arguments to justify his intrusion, a problem that has already been corrected by the district and circuit courts.

6. *The practice of medicine in Oregon*

Unlike the Attorney General, the State of Oregon recognizes the limits and integration of state and federal law. Or. Rev. Stat. 127.815(1)(I)(A) expressly requires physicians and pharmacists practicing under Oregon's unique law to be registered with the Board of Medical Examiners *and* the DEA.[10]

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[9] *See, e.g.*, Pet. Cert., 100a ("regardless of whether state law authorizes or permits such conduct"); 102a ("This conclusion applies regardless of whether state law authorizes or permits such conduct"); 104a ("assist suicides in accordance with Oregon law"); 104a ("in compliance with Oregon Law"); 107a ("even in a manner permitted by state law"); 116a ("legalized physician-assisted suicide"); 131a ("assisting in suicide may be permitted in some cases for Oregon physicians under local law"); 131a ("in accordance with state law"); 133a ("permissible under state law"); 134a ("physicians may assist suicides compatibly with local law"); 148a ("state that had legalized physician-assisted suicide").

[10] *See*, App. 7 (Or. Rev. Stat. 127.815(1)(I)(A)).

As part of his record in support of injunctive relief, Dr. Rasmussen demonstrated that he and others like him practicing under Oregon's unique law are acting in their professional role in conformity with state medical practice standards (App. 22-27), an area that falls squarely within the states' traditional police power. *Linder*, *supra*, 268 U.S. at 18; *Barsky*, *supra* 347 U.S. at 449; *Rush Prudential HMO*, *supra*, 536 U.S at 387.

Or. Rev. Stat. 127.815 establishes the standard of care for an attending physician practicing under the Oregon Death With Dignity Act. App. 4-5.[11] Dr. Rasmussen is acting in the course of his professional practice when he is acting in accord with Oregon's standard of care. He makes an initial determination of whether his patient has a terminal disease, is capable, and has made the request voluntarily. He ensures that the patient is making an informed decision by informing the patient of the patient's medical diagnosis, prognosis, the potential risk and probable result associated with taking the medication to be prescribed, and the feasible alternatives, including, but not limited to, comfort care, hospice care and pain control. Dr. Rasmussen further refers his patients to a consulting physician for medical confirmation of the diagnosis and for a second opinion that the patient is capable and acting voluntarily. When appropriate, Dr. Rasmussen also refers his patients for counseling. He recommends that the patient notify next of kin and counsels the patient about the importance of having another person present when the patient takes

[11] Respondents do not seek to convince this Court that the State of Oregon has made a *correct* policy choice, only that the State of Oregon has made *a* policy choice, implementing a matter of medical policy traditionally reserved to the states.

the medication prescribed under Oregon law. CR 105; App. 24-25, ¶¶ 10, 11.

As required under Oregon law, Dr. Rasmussen dispenses the medications directly, including ancillary medications intended to facilitate the desired effect and minimize the patient's discomfort, or in the alternative, Dr. Rasmussen contacts a pharmacist and informs the pharmacist of the prescription, and he then delivers the written prescription personally or by mail to the pharmacist, who will dispense the medications to either the patient, the attending physician, or the patient's chosen agent. CR 105; App. 25 ¶ 12.

Dr. Rasmussen further satisfies all of the statutory medical documentation requirements and provides a copy of his dispensing record to the Department of Human Services. In sum, Dr. Rasmussen ensures that all appropriate steps are carried out in accordance with Or. Rev. Stat. 127.800 to 127.897, CR 105; App. 25, ¶ 13, exactly what is required of him under state statutory and regulatory law, and the community standard of care. *See, e.g.*, Or. Rev. Stat. 127.815; App. 1-12.

7. *The CSA is a law enforcement statute, not a medical policy act*

Section 101 of the CSA (21 U.S.C. 801) expresses Congressional concern over the "illegal importation, manufacture, distribution, and possession and improper use of controlled substances," and explains why intrastate trafficking in controlled substances must be regulated in order to address the larger drug abuse problem. These legislative findings, along with the text and legislative history, confirm that the CSA was enacted to control

trafficking in illegal drugs, such as heroin and marijuana, and also to prevent diversion of legitimately produced controlled substances into illicit channels. *See, e.g., United States v. Green*, 511 F.2d 1062, 1071 (1975) (pharmacist dispensed over a million Ritalin tablets in less than a year); HR Rep No. 91-1444, 91st Cong, 2d Sess, U.S.C.C.A.N. 4566, 4581 (1970) (in 1965, almost half of the 9 billion amphetamines and barbiturates produced legitimately in this country were diverted into illicit channels). The goal is to establish "a 'closed' system of drug distribution for legitimate handlers of such drugs" to "reduce the widespread diversion of these drugs out of legitimate channels into the illicit market." 91 U.S.C.C.A.N. at 4571-72; *see, also,* S Rep No 98-225, 98th Cong, 1st Sess, U.S.C.C.A.N. 3182, 3442-49 (1983).

The legislative record further demonstrates that the CSA is a law enforcement statute and that Congress never intended that it would be used to regulate medicine or to alter the state/federal framework.

The following excerpts from the 1970 Senate floor debate reveal that the CSA was at first focused solely upon preventing drug trafficking and diversion; it served a law enforcement purpose and no other purpose:

> This measure--in concept, in spirit, and in detail--*is a law-enforcement measure*. It only approaches one side of the problem of drug abuse.

Quoting, Senator Hughes, Cong. Rec., Senate, 973 (January 23, 1970) (emphasis added).

> That is my position on this problem. The legislation before us is a *law enforcement bill*. * * * we concluded it would be better to keep this particular piece of legislation *a law enforcement measure*.

Quoting, Senator Dodd, Cong. Rec., Senate, 976 (January 23, 1970) (emphasis added).

> The proposed legislation provides a regulatory schedule for the lawful manufacture, distribution, and dispensing of controlled drugs to furnish us with better law enforcement tools *so that the rampant drug abuse problem can finally be curbed* effectively.

Quoting, Senator Dodd, Cong. Rec., Senate, 978 (January 23, 1970) (emphasis added).

> But it cannot be overemphasized that the bill before the Senate today is *entirely concerned with enforcement*. It contains no medical or rehabilitative provisions.
>
> It is designed to crack down hard on the narcotics pusher and the illegal diverters of pep pills and goof balls. * * * .

Quoting, Senator Dodd, Cong. Rec., Senate, 978 (January 23, 1970) (emphasis added).

> * * * this title reaffirms the Federal Government's role in drug control. Basically this role is to regulate the legitimate drug trade *to prevent diversion of medically useful dangerous drugs* into illegitimate channels and *to help reduce the criminal traffic* in all narcotic and dangerous drugs on the local, national, and international level.

Quoting, Senator Dodd, Cong. Rec., Senate, 996 (January 24, 1970) (emphasis added).

> *All of these provisions are designed to reduce the diversion of drugs* from the legitimate course of commerce and use into illegal channels. This is important in the face of evidence that about half of the annual production of amphetamine and barbiturate drugs, or between 8 and 9 billion pills, *have been diverted to nonmedical use*.

Quoting, Senator Dodd, Cong. Rec., Senate, 996 (January 24, 1970) (emphasis added).

The debate changed little as it moved to the House. The primary difference was that the House expanded the legislation to include drug research, education and treatment, in addition to the Senate's narrower focus upon the prevention of drug trafficking and diversion. The entire debate remained, however, in the context of the drug problem:

> There are a limited number of approaches to attack this problem—preventive steps, aimed at stopping experimentation before it starts; control, to regulate the supply and availability of drugs; rehabilitation to lead individuals away from drug dependence and addiction. It is my conviction that the Federal Government must make a concentrated effort in all of these areas.

Quoting, Representative Boland, Cong. Rec., House, 33315 (September 23, 1970).

> The word "control" in the title, of course, simply means enforcement by the Justice Department in *problems related to drug abuse*, by any person or corporation whether a manufacturer, wholesaler, or retailer. These controls cover all the hard narcotics and opiates, marijuana, and hallucinogens such as LSD, amphetamines, barbiturates, and even any tranquilizers subject to abuse.

Quoting, Representative Randall, Cong. Rec., House, 33656 (September 24, 1970) (emphasis added).

Here again, nothing from the 1970 House floor debate remotely suggests that Congress intended the Attorney General to determine the "legitimacy of medicine," or to establish medical policy in the states. To better control the rampant drug problem,

the House expanded the reach of the CSA to include drug research, education, treatment, and rehabilitation, but included not a word about regulating medical practice. The relevant language in the proposed legislation did not significantly change when it returned to the Senate later that same year:

> I am particularly grateful that the basic Controlled Dangerous Substances Act was passed in almost its entirety by the House. There were a number of minor disagreements; but more than 90 percent of the law which was reported by the Senate Subcomittee [sic] on Juvenile Delinquency will soon become the law of the land.
>
> This is no mean achievement. The Senate legislation passed the very close scrutiny of the House[,] which investigated the bill for many months. No significant changes were made, a procedure which does not often occur in bills sent over from the Senate.

Quoting, Senator Dodd, Cong. Rec., Senate, 35051, 35052 (October 6, 1970).

The 1984 amendments reveal that once again Congress was concerned about a rampant drug abuse problem, the diversion of otherwise lawful drugs to illicit or recreational uses. The bill was named the Dangerous Drug Diversion Control Act of 1984 and it was described as follows:

> Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 5656) to amend the Controlled Substances Act *to strengthen the authority to prevent diversion of controlled substances*, and for other purposes, as amended.

Quoting, Representative Hughes, Cong. Rec., House, 25846 (September 18, 1984) (emphasis added).

> This bill addresses one of the most critical areas of drug abuse, the abuse of prescription drugs. Prescription drugs are responsible for close to 70 percent of the deaths and injuries due to drug abuse. But I am sorry to say this aspect of drug abuse, *the diversion problem*, has often failed to get the societal or the enforcement attention that it deserves.

Quoting, Representative Hughes, Cong. Rec., House, 25848 (September 18, 1984) (emphasis added). The Attorney General would likely take the above "deaths and injuries" phrase out of context, just as he does in his petition (*see*, Pet. Cert. 22-23--"misuse of a drug in suicides and attempted suicides"), but the Congress was only concerned with illicit use, particularly that flowing from "diversion":

> *Diversion* is the connotation for the various means by which legitimate medical controlled substances are diverted from proper use to improper use. Invalid

prescriptions and pharmacy robberies are two types of retail level *diversion*. While much of the drug enforcement focus has been placed on the interdiction of improperly imported substances, *the problem of domestic diversion has quietly grown to staggering proportions*.

* * * . Abuse of prescription drugs through *diversion* at the manufacturing and distribution levels [is] severely curtailed under the current law by DEA. The vast majority of *diversions* occur at the retail level. * * * .

* * * * *

* * * . *This bill provides the Drug Enforcement Agency with the necessary tools to join State agencies in reducing diversion.*

Quoting, Representative Sawyer, Cong. Rec., House, 25849 (September 18, 1984) (emphasis added).

> Mr. Speaker, I rise in strong support of H.R. 5656, the *Dangerous Drug Diversion Control Act* of 1984. The bill amends the Controlled Substances Act to attempt *to prevent the diversion of controlled substances* from legitimate channels of medical distribution and administration to illegitimate channels for purposes of abuse. Evidence suggests that prescription drugs *diverted* by legitimate medical distributors to the illicit drug market account for about three-fourths of deaths and injuries due to drug abuse.

Quoting, Representative Gilman, Cong. Rec., House, 25851 (September 18, 1984) (emphasis added).

In sum, whether reviewing the 1970 or the 1984 legislative history, it is clear that the CSA was intended as a solution to the problems of illicit drug use, drug trafficking, and drug diversion. The CSA was never intended to empower the Attorney General to rule upon the legitimacy of medical practice in the States.

8. *The Attorney General fails to allege a single incident of illicit drug use, drug trafficking, or drug diversion*

Contrary to the requirements of the CSA and the expectations of Congress, the record in the instant case is entirely devoid of any evidence or even an allegation of illicit drug use, drug trafficking, or drug diversion. There are, for example, none of the usual allegations that banned drugs are being used, or that physicians practicing under the Oregon law are diverting otherwise lawful drugs to an illicit use. Large quantities are not prescribed, large numbers of prescriptions are not issued, patients are not instructed to fill their prescriptions at different drug stores, prescriptions are not issued for one person but privately intended for another, prescriptions are neither issued nor filled to satisfy the cravings of an addict, multiple prescriptions are not "spread out" to avoid detection, and practitioners are not accused of using street slang. In an apparent attempt to overcome this shortcoming, the Attorney General argues that, "the taking of drugs to commit suicide is drug abuse" (Pet. Cert., 23), but this is merely an

incomplete and argumentative statement of the issue, and not the "serious, thoughtful examination" of the issue that this Court observed in *Glucksberg*, *supra*, 521 U.S. at 719.

CONCLUSION

While this litigation may present interesting policy questions, in view of the plain language of the relevant statutes and the extensive legislative history, the legal questions are relatively simple. DEA registrants practicing pursuant to Oregon statutory and regulatory law are acting in the course of their professional practice, consistent with the terms of the CSA. The Attorney General's contrary interpretation of this same statutory scheme seeks to accomplish too much. *Raygor v. Regents of University of Minnesota*, 534 U.S. 533, 543 (2002) ("When Congress intends to alter the usual constitutional balance between the States and the Federal Government, it must make its intention to do so unmistakably clear in the language of the statute").

FOR THE FOREGOING REASONS, Peter A. Rasmussen, M.D., and David M. Hochhalter, Rph, urge that the Attorney General's petition be denied.

Respectfully submitted,

ELI D. STUTSMAN
Counsel of Record
621 SW Morrison
Thirteenth Floor
Portland, OR 97205
(503) 274-4048

January 10, 2005

APPENDIX

APPENDIX

The Oregon Death With Dignity Act 1

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THE OREGON DEATH WITH DIGNITY ACT
(General Provisions)

(Section 1)

Note: The division headings, subdivision headings and leadlines for 127.800 to 127.890, 127.895 and 127.897 were enacted as part of Ballot Measure 16 (1994) and were not provided by Legislative Counsel.

127.800 §1.01. Definitions. The following words and phrases, whenever used in ORS 127.800 to 127.897, have the following meanings:

(1) "Adult" means an individual who is 18 years of age or older.

(2) "Attending physician" means the physician who has primary responsibility for the care of the patient and treatment of the patient's terminal disease.

(3) "Capable" means that in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, psychiatrist or psychologist, a patient has the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available.

(4) "Consulting physician" means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's disease.

(5) "Counseling" means one or more consultations as necessary between a state licensed psychiatrist or psychologist and a patient for the purpose of determining that the patient is capable and not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.

(6) "Health care provider" means a person licensed, certified or otherwise authorized or permitted by the law of this state to administer health care or dispense medication in the ordinary course of business or practice of a profession, and includes a health care facility.

(7) "Informed decision" means a decision by a qualified patient, to request and obtain a prescription to end his or her life in a humane and dignified manner, that is based on an appreciation of the relevant facts and after being fully informed by the attending physician of:

(a) His or her medical diagnosis;

(b) His or her prognosis;

(c) The potential risks associated with taking the medication to be prescribed;

(d) The probable result of taking the medication to be prescribed; and

(e) The feasible alternatives, including, but not limited to, comfort care, hospice care and pain control.

(8) "Medically confirmed" means the medical opinion of the attending physician has been confirmed by a consulting physician who has examined the patient and the patient's relevant medical records.

(9) "Patient" means a person who is under the care of a physician.

(10) "Physician" means a doctor of medicine or osteopathy licensed to practice medicine by the Board of Medical Examiners for the State of Oregon.

(11) "Qualified patient" means a capable adult who is a resident of Oregon and has satisfied the requirements of ORS 127.800 to 127.897 in order to obtain a prescription for medication to end his or her life in a humane and dignified manner.

(12) "Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months. [1995 c.3 §1.01; 1999 c.423 §1]

(Written Request for Medication to End One's Life in a Humane and Dignified Manner)

(Section 2)

127.805 §2.01. Who may initiate a written request for medication. (1) An adult who is capable, is a resident of Oregon, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and

who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner in accordance with ORS 127.800 to 127.897.

(2) No person shall qualify under the provisions of ORS 127.800 to 127.897 solely because of age or disability. [1995 c.3 §2.01; 1999 c.423 §2]

127.810 §2.02. Form of the written request. (1) A valid request for medication under ORS 127.800 to 127.897 shall be in substantially the form described in ORS 127.897, signed and dated by the patient and witnessed by at least two individuals who, in the presence of the patient, attest that to the best of their knowledge and belief the patient is capable, acting voluntarily, and is not being coerced to sign the request.

(2) One of the witnesses shall be a person who is not:

(a) A relative of the patient by blood, marriage or adoption;

(b) A person who at the time the request is signed would be entitled to any portion of the estate of the qualified patient upon death under any will or by operation of law; or

(c) An owner, operator or employee of a health care facility where the qualified patient is receiving medical treatment or is a resident.

(3) The patient's attending physician at the time the request is signed shall not be a witness.

(4) If the patient is a patient in a long term care facility at the time the written request is made, one of the witnesses shall be an individual designated by the facility and having the qualifications specified by the Department of Human Services by rule. [1995 c.3 §2.02]

(Safeguards)

(Section 3)

127.815 §3.01. Attending physician responsibilities. (1) The attending physician shall:

(a) Make the initial determination of whether a patient has a terminal disease, is capable, and has made the request voluntarily;

(b) Request that the patient demonstrate Oregon residency pursuant to ORS 127.860;

(c) To ensure that the patient is making an informed decision, inform the patient of:

(A) His or her medical diagnosis;

(B) His or her prognosis;

(C) The potential risks associated with taking the medication to be prescribed;

(D) The probable result of taking the medication to be prescribed; and

(E) The feasible alternatives, including, but not limited to, comfort care, hospice care and pain control;

(d) Refer the patient to a consulting physician for medical confirmation of the diagnosis, and for a determination that the patient is capable and acting voluntarily;

(e) Refer the patient for counseling if appropriate pursuant to ORS 127.825;

(f) Recommend that the patient notify next of kin;

(g) Counsel the patient about the importance of having another person present when the patient takes the medication prescribed pursuant to ORS 127.800 to 127.897 and of not taking the medication in a public place;

(h) Inform the patient that he or she has an opportunity to rescind the request at any time and in any manner, and offer the patient an opportunity to rescind at the end of the 15 day waiting period pursuant to ORS 127.840;

(i) Verify, immediately prior to writing the prescription for medication under ORS 127.800 to 127.897, that the patient is making an informed decision;

(j) Fulfill the medical record documentation requirements of ORS 127.855;

(k) Ensure that all appropriate steps are carried out in accordance with ORS 127.800 to 127.897 prior to writing a

prescription for medication to enable a qualified patient to end his or her life in a humane and dignified manner; and

(l)(A) Dispense medications directly, including ancillary medications intended to facilitate the desired effect to minimize the patient's discomfort, provided the attending physician is registered as a dispensing physician with the Board of Medical Examiners, has a current Drug Enforcement Administration certificate and complies with any applicable administrative rule; or

(B) With the patient's written consent:

(i) Contact a pharmacist and inform the pharmacist of the prescription; and

(ii) Deliver the written prescription personally or by mail to the pharmacist, who will dispense the medications to either the patient, the attending physician or an expressly identified agent of the patient.

(2) Notwithstanding any other provision of law, the attending physician may sign the patient's death certificate. [1995 c.3 §3.01; 1999 c.423 §3]

127.820 §3.02. Consulting physician confirmation. Before a patient is qualified under ORS 127.800 to 127.897, a consulting physician shall examine the patient and his or her relevant medical records and confirm, in writing, the attending physician's diagnosis that the patient is suffering from a terminal disease, and verify that the patient is capable, is acting voluntarily and has made an informed decision. [1995 c.3 §3.02]

127.825 §3.03. Counseling referral. If in the opinion of the attending physician or the consulting physician a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment, either physician shall refer the patient for counseling. No medication to end a patient's life in a humane and dignified manner shall be prescribed until the person performing the counseling determines that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment. [1995 c.3 §3.03; 1999 c.423 §4]

127.830 §3.04. Informed decision. No person shall receive a prescription for medication to end his or her life in a humane and dignified manner unless he or she has made an informed decision as defined in ORS 127.800 (7). Immediately prior to writing a prescription for medication under ORS 127.800 to 127.897, the attending physician shall verify that the patient is making an informed decision. [1995 c.3 §3.04]

127.835 §3.05. Family notification. The attending physician shall recommend that the patient notify the next of kin of his or her request for medication pursuant to ORS 127.800 to 127.897. A patient who declines or is unable to notify next of kin shall not have his or her request denied for that reason. [1995 c.3 §3.05; 1999 c.423 §6]

127.840 §3.06. Written and oral requests. In order to receive a prescription for medication to end his or her life in a humane and dignified manner, a qualified patient shall have made an oral request and a written request, and reiterate the oral request to his or her attending physician no less than fifteen (15) days after making the initial oral request. At the time the

qualified patient makes his or her second oral request, the attending physician shall offer the patient an opportunity to rescind the request. [1995 c.3 §3.06]

127.845 §3.07. Right to rescind request. A patient may rescind his or her request at any time and in any manner without regard to his or her mental state. No prescription for medication under ORS 127.800 to 127.897 may be written without the attending physician offering the qualified patient an opportunity to rescind the request. [1995 c.3 §3.07]

127.850 §3.08. Waiting periods. No less than fifteen (15) days shall elapse between the patient's initial oral request and the writing of a prescription under ORS 127.800 to 127.897. No less than 48 hours shall elapse between the patient's written request and the writing of a prescription under ORS 127.800 to 127.897. [1995 c.3 §3.08]

127.855 §3.09. Medical record documentation requirements. The following shall be documented or filed in the patient's medical record:

(1) All oral requests by a patient for medication to end his or her life in a humane and dignified manner;

(2) All written requests by a patient for medication to end his or her life in a humane and dignified manner;

(3) The attending physician's diagnosis and prognosis, determination that the patient is capable, acting voluntarily and has made an informed decision;

(4) The consulting physician's diagnosis and prognosis, and verification that the patient is capable, acting voluntarily and has made an informed decision;

(5) A report of the outcome and determinations made during counseling, if performed;

(6) The attending physician's offer to the patient to rescind his or her request at the time of the patient's second oral request pursuant to ORS 127.840; and

(7) A note by the attending physician indicating that all requirements under ORS 127.800 to 127.897 have been met and indicating the steps taken to carry out the request, including a notation of the medication prescribed. [1995 c.3 §3.09]

127.860 §3.10. Residency requirement. Only requests made by Oregon residents under ORS 127.800 to 127.897 shall be granted. Factors demonstrating Oregon residency include but are not limited to:

(1) Possession of an Oregon driver license;

(2) Registration to vote in Oregon;

(3) Evidence that the person owns or leases property in Oregon; or

(4) Filing of an Oregon tax return for the most recent tax year. [1995 c.3 §3.10; 1999 c.423 §8]

127.865 §3.11. Reporting requirements. (1)(a) The Department of Human Services shall annually review a sample of records maintained pursuant to ORS 127.800 to 127.897.

(b) The department shall require any health care provider upon dispensing medication pursuant to ORS 127.800 to 127.897 to file a copy of the dispensing record with the department.

(2) The department shall make rules to facilitate the collection of information regarding compliance with ORS 127.800 to 127.897. Except as otherwise required by law, the information collected shall not be a public record and may not be made available for inspection by the public.

(3) The department shall generate and make available to the public an annual statistical report of information collected under subsection (2) of this section. [1995 c.3 §3.11; 1999 c.423 §9; 2001 c.104 §40]

127.870 §3.12. Effect on construction of wills, contracts and statutes. (1) No provision in a contract, will or other agreement, whether written or oral, to the extent the provision would affect whether a person may make or rescind a request for medication to end his or her life in a humane and dignified manner, shall be valid.

(2) No obligation owing under any currently existing contract shall be conditioned or affected by the making or rescinding of a request, by a person, for medication to end his or her life in a humane and dignified manner. [1995 c.3 §3.12]

127.875 §3.13. Insurance or annuity policies. The sale, procurement, or issuance of any life, health, or accident insurance or annuity policy or the rate charged for any policy shall not be conditioned upon or affected by the making or rescinding of a request, by a person, for medication to end his or her life in a humane and dignified manner. Neither shall a qualified patient's act of ingesting medication to end his or her life in a humane and dignified manner have an effect upon a life, health, or accident insurance or annuity policy. [1995 c.3 §3.13]

127.880 §3.14. Construction of Act. Nothing in ORS 127.800 to 127.897 shall be construed to authorize a physician or any other person to end a patient's life by lethal injection, mercy killing or active euthanasia. Actions taken in accordance with ORS 127.800 to 127.897 shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law. [1995 c.3 §3.14]

(Immunities and Liabilities)

(Section 4)

127.885 §4.01. Immunities; basis for prohibiting health care provider from participation; notification; permissible sanctions. Except as provided in ORS 127.890:

(1) No person shall be subject to civil or criminal liability or professional disciplinary action for participating in good faith compliance with ORS 127.800 to 127.897. This includes being present when a qualified patient takes the

prescribed medication to end his or her life in a humane and dignified manner.

(2) No professional organization or association, or health care provider, may subject a person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership or other penalty for participating or refusing to participate in good faith compliance with ORS 127.800 to 127.897.

(3) No request by a patient for or provision by an attending physician of medication in good faith compliance with the provisions of ORS 127.800 to 127.897 shall constitute neglect for any purpose of law or provide the sole basis for the appointment of a guardian or conservator.

(4) No health care provider shall be under any duty, whether by contract, by statute or by any other legal requirement to participate in the provision to a qualified patient of medication to end his or her life in a humane and dignified manner. If a health care provider is unable or unwilling to carry out a patient's request under ORS 127.800 to 127.897, and the patient transfers his or her care to a new health care provider, the prior health care provider shall transfer, upon request, a copy of the patient's relevant medical records to the new health care provider.

(5)(a) Notwithstanding any other provision of law, a health care provider may prohibit another health care provider from participating in ORS 127.800 to 127.897 on the premises of the prohibiting provider if the prohibiting provider has notified the health care provider of the prohibiting provider's

policy regarding participating in ORS 127.800 to 127.897. Nothing in this paragraph prevents a health care provider from providing health care services to a patient that do not constitute participation in ORS 127.800 to 127.897.

(b) Notwithstanding the provisions of subsections (1) to (4) of this section, a health care provider may subject another health care provider to the sanctions stated in this paragraph if the sanctioning health care provider has notified the sanctioned provider prior to participation in ORS 127.800 to 127.897 that it prohibits participation in ORS 127.800 to 127.897:

(A) Loss of privileges, loss of membership or other sanction provided pursuant to the medical staff bylaws, policies and procedures of the sanctioning health care provider if the sanctioned provider is a member of the sanctioning provider's medical staff and participates in ORS 127.800 to 127.897 while on the health care facility premises, as defined in ORS 442.015, of the sanctioning health care provider, but not including the private medical office of a physician or other provider;

(B) Termination of lease or other property contract or other nonmonetary remedies provided by lease contract, not including loss or restriction of medical staff privileges or exclusion from a provider panel, if the sanctioned provider participates in ORS 127.800 to 127.897 while on the premises of the sanctioning health care provider or on property that is owned by or under the direct control of the sanctioning health care provider; or

(C) Termination of contract or other nonmonetary remedies provided by contract if the sanctioned provider

participates in ORS 127.800 to 127.897 while acting in the course and scope of the sanctioned provider's capacity as an employee or independent contractor of the sanctioning health care provider. Nothing in this subparagraph shall be construed to prevent:

(i) A health care provider from participating in ORS 127.800 to 127.897 while acting outside the course and scope of the provider's capacity as an employee or independent contractor; or

(ii) A patient from contracting with his or her attending physician and consulting physician to act outside the course and scope of the provider's capacity as an employee or independent contractor of the sanctioning health care provider.

(c) A health care provider that imposes sanctions pursuant to paragraph (b) of this subsection must follow all due process and other procedures the sanctioning health care provider may have that are related to the imposition of sanctions on another health care provider.

(d) For purposes of this subsection:

(A) "Notify" means a separate statement in writing to the health care provider specifically informing the health care provider prior to the provider's participation in ORS 127.800 to 127.897 of the sanctioning health care provider's policy about participation in activities covered by ORS 127.800 to 127.897.

(B) "Participate in ORS 127.800 to 127.897" means to perform the duties of an attending physician pursuant to ORS

127.815, the consulting physician function pursuant to ORS 127.820 or the counseling function pursuant to ORS 127.825. "Participate in ORS 127.800 to 127.897" does not include:

(i) Making an initial determination that a patient has a terminal disease and informing the patient of the medical prognosis;

(ii) Providing information about the Oregon Death with Dignity Act to a patient upon the request of the patient;

(iii) Providing a patient, upon the request of the patient, with a referral to another physician; or

(iv) A patient contracting with his or her attending physician and consulting physician to act outside of the course and scope of the provider's capacity as an employee or independent contractor of the sanctioning health care provider.

(6) Suspension or termination of staff membership or privileges under subsection (5) of this section is not reportable under ORS 441.820. Action taken pursuant to ORS 127.810, 127.815, 127.820 or 127.825 shall not be the sole basis for a report of unprofessional or dishonorable conduct under ORS 677.415 (2) or (3).

(7) No provision of ORS 127.800 to 127.897 shall be construed to allow a lower standard of care for patients in the community where the patient is treated or a similar community. [1995 c.3 §4.01; 1999 c.423 §10]

Note: As originally enacted by the people, the leadline to section 4.01 read "Immunities." The remainder of the leadline was added by editorial action.

127.890 §4.02. Liabilities. (1) A person who without authorization of the patient willfully alters or forges a request for medication or conceals or destroys a rescission of that request with the intent or effect of causing the patient's death shall be guilty of a Class A felony.

(2) A person who coerces or exerts undue influence on a patient to request medication for the purpose of ending the patient's life, or to destroy a rescission of such a request, shall be guilty of a Class A felony.

(3) Nothing in ORS 127.800 to 127.897 limits further liability for civil damages resulting from other negligent conduct or intentional misconduct by any person.

(4) The penalties in ORS 127.800 to 127.897 do not preclude criminal penalties applicable under other law for conduct which is inconsistent with the provisions of ORS 127.800 to 127.897. [1995 c.3 §4.02]

127.892 Claims by governmental entity for costs incurred. Any governmental entity that incurs costs resulting from a person terminating his or her life pursuant to the provisions of ORS 127.800 to 127.897 in a public place shall have a claim against the estate of the person to recover such costs and reasonable attorney fees related to enforcing the claim. [1999 c.423 §5a]

(Severability)

(Section 5)

127.895 §5.01. Severability. Any section of ORS 127.800 to 127.897 being held invalid as to any person or circumstance shall not affect the application of any other section of ORS 127.800 to 127.897 which can be given full effect without the invalid section or application. [1995 c.3 §5.01]

(Form of the Request)

(Section 6)

127.897 §6.01. Form of the request. A request for a medication as authorized by ORS 127.800 to 127.897 shall be in substantially the following form:

REQUEST FOR MEDICATION
TO END MY LIFE IN A HUMANE
AND DIGNIFIED MANNER

I, _____, am an adult of sound mind.

I am suffering from _____, which my attending physician has determined is a terminal disease and which has been medically confirmed by a consulting physician.

I have been fully informed of my diagnosis, prognosis, the nature of medication to be prescribed and potential associated

risks, the expected result, and the feasible alternatives, including comfort care, hospice care and pain control.

I request that my attending physician prescribe medication that will end my life in a humane and dignified manner.

INITIAL ONE:

_____ I have informed my family of my decision and taken their opinions into consideration.

_____ I have decided not to inform my family of my decision.

_____ I have no family to inform of my decision.

I understand that I have the right to rescind this request at any time.

I understand the full import of this request and I expect to die when I take the medication to be prescribed. I further understand that although most deaths occur within three hours, my death may take longer and my physician has counseled me about this possibility.

I make this request voluntarily and without reservation, and I accept full moral responsibility for my actions.

Signed: _____

Dated: _____

DECLARATION OF WITNESSES

We declare that the person signing this request:

(a) Is personally known to us or has provided proof of identity;

(b) Signed this request in our presence;

(c) Appears to be of sound mind and not under duress, fraud or undue influence;

(d) Is not a patient for whom either of us is attending physician.

_____Witness 1/Date

_____Witness 2/Date

NOTE: One witness shall not be a relative (by blood, marriage or adoption) of the person signing this request, shall not be entitled to any portion of the person's estate upon death and shall not own, operate or be employed at a health care facility where the person is a patient or resident. If the patient is an inpatient at a health care facility, one of the witnesses shall be an individual designated by the facility.

163.125 Manslaughter in the second degree. (1) Criminal homicide constitutes manslaughter in the second degree when:

(a) It is committed recklessly;

(b) A person intentionally causes or aids another person to commit suicide [underscore added]; or

(c) A person, with criminal negligence, causes the death of a child under 14 years of age or a dependent person, as defined in ORS 163.205, and:

(A) The person has previously engaged in a pattern or practice of assault or torture of the victim or another child under 14 years of age or a dependent person; or

(B) The person causes the death by neglect or maltreatment, as defined in ORS 163.115.

(2) Manslaughter in the second degree is a Class B felony. [1971 c.743 §89; 1975 c.577 §3; 1997 c.850 §4; 1999 c.954 §1]

AFFIDAVIT OF PETER A. RASMUSSEN, M.D., IN SUPPORT OF MOTION FOR SUMMARY JUDGMENT FILED BY PETER A. RASMUSSEN, M.D., AND DAVID M. HOCHHALTER, RPh

STATE OF OREGON)
) ss.
County of Marion)

I, Peter A. Rasmussen, M.D., being duly sworn, make this affidavit based on personal knowledge in support of summary judgment in my favor, as follows:

1. I am a medical oncologist licensed to practice medicine in the State of Oregon. I am Board Certified in Hospice and Palliative Medicine.

2. I am also registered with the Drug Enforcement Administration (DEA) and am authorized to prescribe and dispense controlled substances under both state and federal law.

3. As a medical oncologist and DEA registrant, I have treated terminally ill patients for 21 years in Oregon. I estimate that I am currently treating hundreds of patients facing a terminal disease.

4. Since passage of the Oregon Death With Dignity Act, I have received many requests from patients seeking information or assistance under the Act. As an attending physician and DEA registrant, I have participated under the Oregon Death With Dignity Act several times and, when appropriate under the Act, I have written prescriptions for controlled Substances, but not Schedule I substances. I have provided copies of my dispensing records to the Department of

Human Services as required under the Oregon Death With Dignity Act.

5. At the time of this affidavit, three of my patients have satisfied all of the requirements of the Oregon Death With Dignity Act. All three are qualified to obtain prescriptions under the Act. In order to preserve patient confidentiality, I will identify them by profile:

Patient A Patient A is a woman approximately 64 years old who is dying from ovarian cancer. She has satisfied all of the requirements necessary under Oregon law to obtain controlled substances to hasten her death.

Patient B Patient B is a man approximately 72 years old who is dying from lung cancer. He has satisfied all of the requirements necessary under Oregon law to obtain controlled substances to hasten his death.

Patient C Patient C is a woman approximately 52 years old who is also dying from ovarian cancer. She has satisfied all of the requirements necessary under Oregon law to obtain controlled substances to hasten her death.

6. I cannot predict whether any of these patients will choose to hasten their impending deaths, but all three are qualified under the law to do so. I am currently attending to their needs on an ongoing basis. For example, the prescription for Patient B has already been written and filled and I have the controlled substance in my possession should Patient B decide to use it.

7. Patients A and C both know of my role in this litigation. Both Patients A and C have expressed their support and appreciation for my willingness to represent their interests. For my patients that support the options available to them under

the Oregon Death With Dignity Act, I am intentionally representing their interests in this litigation.

8. Due to the nature of my practice, at any given time, many of my patients will be terminally ill and I will continue to receive requests from patients for prescriptions and information under the Oregon Death With Dignity Act.

9. Prior to court's issuance of a temporary restraining order, my ability to meet the community standard of care as established under Oregon law and practice was severely restricted. As the direct result of this court's preliminary injunctive relief, my ability to meet the community standard of care as established under Oregon law and practice has been restored.

10. As the attending physician under the Oregon Death With Dignity Act I am practicing legitimate medicine in the course of my professional practice. I comply with both state law and the standard of care when I fulfill the criteria of an "attending physician" as required by section 127.815 of the Act. For example, I make the initial determination of whether my patients have a terminal disease, are capable, and have made their request voluntarily. I ensure that my patients are informed by informing them of their medical diagnosis, prognosis, the potential risk and probable result associated with taking the medication to be prescribed, and the feasible alternatives, including, but not limited to, comfort care, hospice care and pain control.

11. I further refer my patients to a consulting physician for medical confirmation of the diagnosis, and for a second opinion that my patients are capable and acting voluntarily. When appropriate, I also refer my patients for counseling. I recommend that my patients notify their next of kin and counsel them about the importance of having another

person present when they take the medication prescribed under the Oregon Death With Dignity Act. I further inform my patients that they may change their minds at any time, in any manner, and I remind my patients of this right throughout the process, including immediately prior to writing the prescription, at which point I again confirm that the patient is again making an informed decision.

12. As required under the Oregon Death With Dignity Act, I dispense the medications directly, including ancillary medications intended to facilitate the desired effect and minimize any discomfort. Or, in the alternative, I contact a pharmacist and inform the pharmacist of the prescription. I then deliver the written prescription personally or by mail to the pharmacist, who will dispense the medications to either the patient, to me as the attending physician, or the patient's chosen representative. I am at all times registered as a dispensing physician with the Board of Medical Examiners and I have a current Drug Enforcement Administration certificate.

13. I further satisfy all the statutory medical record documentation requirements and provide a copy of my dispensing record to the Department of Human Services. In general, I ensure that all appropriate steps are carried out in accordance with ORS 127.800 to 127.897 prior to writing a prescription for medication to enable a qualified patient to hasten his or her death. I comply with all the provisions of the Oregon Death With Dignity Act. I never engage in drug trafficking or diversion. As a physician practicing under the Oregon Death With Dignity Act, I am practicing legitimate medicine in the course of my professional practice.

14. I encourage this court to award summary judgment in my favor so that I may continue to meet my patients needs under Oregon statutory law, regulatory law, and

the community standard of care established in the State of Oregon.

15. As a physician, I encourage patients to be in charge of their own care. An important part of what a physician does is to describe options and counsel patients on these options. Depriving me of the ability to participate under the Oregon Death With Dignity Act reduces the number of options available to my patients and will lead to unnecessary suffering for terminally ill patients.

16. If the DEA enforcement promise i[s] not enjoined, I will need to inform my patients that I cannot risk participation under the Oregon Death With Dignity Act. Due to Attorney General John Ashcroft's directive to enforce the Controlled Substances Act against physicians like myself practicing in accord with Oregon law and the community standard of care, and in the absence of a permanent injunction, I will no longer be able to meet the community standard of care as established under Oregon law and practice. I cannot risk DEA registration revocation proceedings or other sanctions, criminal and financial. I cannot risk my ability to practice as a medical oncologist, which has provided my livelihood for 21 years. Nor can I risk my family's security, or my ability to provide for my family.

17. In the absence of a permanent injunction, the Oregon Death With Dignity Act will be rendered useless. Only controlled substances are suitable for use under the Oregon Death With Dignity Act; they are used for what Oregon has determined to be a legitimate medical purpose in the normal course of medical practice in Oregon. These controlled substances are prescribed by physicians and dispensed by pharmacies for other purposes as well. Prescriptions for controlled substances under the Oregon Death With Dignity Act

are written by state-licensed physicians and filled by state-licensed pharmacists, in full compliance with the closed system of procedures established by the CSA and enforced by the DEA. These drugs are not otherwise available.

18. Time is important and admittedly short for my patients. Some of my patients face particularly dire circumstances. Once they are qualified to receive a prescription under the Oregon Death With Dignity Act they are by definition "terminally ill," having six months or less to live. Consequently, there will be only a short period of time before they lose their competency, ability to self-administer, or die from their underlying disease. For my patients, and others patients similarly situated, DEA enforcement should be permanently enjoined.

DATED this __ day of January, 2002.

_____
Peter A. Rasmussen, M.D.

SUBSCRIBED AND SWORN TO before me this ___ day of January, 2002.

_____
NOTARY PUBLIC FOR OREGON
My Commission Expires: _____

AFFIDAVIT OF DAVID M. HOCHHALTER, RPh IN SUPPORT OF MOTION FOR SUMMARY JUDGMENT FILED BY PETER A. RASMUSSEN, M.D., AND DAVID M. HOCHHALTER, RPh

STATE OF OPEGON)
) ss.
County of Marion)

I, David M. Hochhalter, RPh, being duly sworn, make this affidavit based on personal knowledge in support of summary judgment in my favor, as follows:

1. I am a pharmacist licensed to practice in the State of Oregon. I have been a pharmacist for almost 23 years. I also own a pharmacy that is registered with the Drug Enforcement Administration (DEA). I am authorized to possess and dispense controlled substances under both state and federal law.

2. As a licensed Oregon pharmacist and DEA registrant, I dispense controlled substances in Oregon.

3. As a licensed Oregon pharmacist and DEA registrant, I have previously filled prescriptions under the Oregon Death with Dignity Act working in conjunction with Dr. Peter Rasmussen. I have filled prescriptions for Dr. Rasmussen during the pendency of this litigation, as recently as last week.

4. As a licensed Oregon pharmacist and DEA registrant, I will continue to fill prescriptions written by Dr. Rasmussen under the Oregon Death With Dignity Act.

5. In the absence of a permanent injunction, the Oregon Death With Dignity Act will be rendered useless. Only controlled substances are suitable for use under the Oregon Death With Dignity Act; they are used for what Oregon has determined to be a legitimate medical purpose in the normal course of medical practice in Oregon. These controlled substances are prescribed by physicians and dispensed by pharmacies for other purposes as well. Prescriptions for controlled substances under the Oregon Death with Dignity Act are written by state-licensed physicians and filled by state-licensed pharmacists, in full compliance with the closed system of procedures established by the CSA. These drugs are not otherwise available. I never engage in drug trafficking or diversion. As a pharmacist dispensing under the Oregon Death With Dignity Act, I am practicing legitimate medicine in the normal course of my professional practice.

6. In the absence of a permanent injunction against Attorney General John Ashcroft's directive to the DEA to enforce the Controlled Substances Act against DEA registrants like myself, practicing in accord with Oregon law and the community standard of care, I can no longer participate under the Oregon Death With Dignity Act. If the court's temporary stay against DEA enforcement is not converted into a permanent injunction, I will need to inform Dr. Rasmussen and our patients that I cannot risk participation under the Oregon Death With Dignity Act. Even if Dr. Rasmussen were willing to write the prescriptions, I would be precluded from filling them because I cannot risk DEA registration revocation proceedings or other sanctions, criminal and financial. I cannot risk my livelihood, or my family's security.

DATED this __ day of January, 2002.

_____
David Malcom Hochhalter, RPh,

SUBSCRIBED AND SWORN TO before me this ___ day of January, 2002.

_____
NOTARY PUBLIC FOR OREGON
My Commission Expires: _____

STATE OF OREGON)
) ss.
County of Marion)

I, David M. Hochhalter, RPh, being duly sworn, make this affidavit based on personal knowledge in support of summary judgment in my favor, as follows:

1. I am a pharmacist licensed to practice in the State of Oregon. I have been a pharmacist for almost 23 years. I also own a pharmacy that is registered with the Drug Enforcement Administration (DEA). I am authorized to possess and dispense controlled substances under both state and federal law.

2. As a licensed Oregon pharmacist and DEA registrant, I dispense controlled substances in Oregon.

3. As a licensed Oregon pharmacist and DEA registrant, I have previously filled prescriptions under the Oregon Death with Dignity Act.

4. Based upon my personal experience and my knowledge of medical practice under the Oregon Death with Dignity Act, two drugs have been used to hasten a terminally ill patient's death, Seconal (9 grams), or Nembutal (10 grams). The full retail price is $68.55 for 9 grams of Seconal, and $133.55 for 10 grams of Nembutal. Seconal was the preferred drug until November of 2001 when supplies ran short. Since November of 2001, Nembutal has been used. I expect that

Seconal will once again be the preferred drug when supplies and inventories are restored to normal.

DATED this ___ day of April, 2002.

_____
David Malcom Hochhalter, RPh,

SUBSCRIBED AND SWORN TO before me this ___ day of April, 2002.

_____
NOTARY PUBLIC FOR OREGON
My Commission Expires: _____